IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF OHIO

EASTERN DIVISION

UNITED STATES OF AMERICA,	)	INDICTMENT
	)	
Plaintiff,	)	CASE NO. 1:08CR0168
	)	
v.	)	JUDGE JUDGE POLSTER
	)	
HAROLD M. JONES,	)	Title 18, United States Code, Sections
	)	1341, 1347, 1028A
Defendant.	)	

The Grand Jury charges:

I. BACKGROUND

At all times material to this Indictment:

Medicare

1. The Medicare Program was enacted by Congress on July 30, 1965, under Title XVIII of the Social Security Act. Medicare provided medical insurance benefits to any person age 65 or older, to certain disabled persons and to those with chronic renal disease who elected coverage. Medicare was a health care benefit program within the meaning of 18 U.S.C. §§ 24(b) and 1347.

2. The Centers for Medicare and Medicaid Services (CMS), formerly known as the

Health Care Finance Administration (HCFA), was the agency of the United States Department of Health and Human Services (HHS) delegated with administering the Medicare program.

3. Medicare paid benefits to medical providers, on the basis of reasonable charges for covered services provided to beneficiaries, pursuant to provider agreements entered into between Medicare and participating physicians.

4. Nationwide Mutual Insurance Company (Nationwide) was the Medicare Part B contractor in Ohio until June 30, 2002. Thereafter, until the present time, the contractor has been Palmetto Government Benefits Administration (Palmetto). These contractors were private organizations under contract with CMS to review, process, and pay Medicare claims on a reasonable charge basis.

5. Medical providers who provided services under provider agreements with Medicare Part B made claims for payment to the Medicare contractor on a Medicare health insurance claim Form HCFA 1500. Medicare contractors processed the Forms 1500 and issued Medicare funded checks, mailed or transferred electronically, to the medical provider for approved services. Medicare only permits payment for treatment that is medically necessary and that meets its criteria for billing of services. Medicare medical providers agree to know those criteria, which Medicare communicates to them through Provider Agreements, the Medicare Policy Manual, and by mail and electronically via its regularly distributed Local Medical Review Policies and Medicare Newsletters.

6. The Medicare provider agreement states:

> **I agree to abide by the Medicare laws, regulations, and program instructions that apply to me. The Medicare laws, regulations, and program instructions are available through the Medicare contractor.**

I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on my compliance with any applicable conditions of participation in Medicare.

I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

7. AdvanceMed, located in Grove City, Ohio, was the Program Safeguard Contractor (PSC) for Medicare in Ohio. The PSC was a private organization under contract with CMS to reduce Medicare claims billing error rates by seeking to reduce fraud and abuse.

8. The medical providers are assigned a Medicare identification number, called a Provider Identification Number (PIN), for billing purposes. PIN numbers are assigned to individual medical providers or to groups of medical providers. PIN numbers are specific to each medical provider or medical group. No two medical providers are assigned the same PIN.

9. On each Form HCFA 1500, the medical provider certified and acknowledged the following:

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

* * * *

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate

personal supervision.

* * * *

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

10. In order to submit claims electronically, medical providers execute an Electronic Data Interchange (EDI) Enrollment Form. As part of this form, medical providers agreed to the following provisions, among others, for submitting Medicare claims electronically to CMS or to CMS's contractors:

That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and CMS guidelines.

* * * *

That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid.

That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law.

11. Defendant has been a participating Medicare medical provider since May 1, 1993, pursuant to his written Medicare provider agreement.

Defendant submitted Medicare claims electronically and receives payment of those claims via U.S. mail.

Medicaid

12. The Medicaid program provided medical insurance coverage for individuals who were disabled or of low income. Medicaid was a health care benefit program within the meaning of 18 U.S.C. §§ 24(b) and 1347.

13. The federal government funded approximately sixty percent of Ohio's Medicaid program. The Ohio Department of Job and Family Services (ODJFS) administered Ohio's Medicaid program. ODJFS reviewed and processed claims and issued checks to medical providers for claims that met Medicaid criteria. Medical providers who submitted claims for services rendered to persons eligible for both Medicare and Medicaid received payment from Medicaid for the amount that Medicare did not pay, known as a "crossover" payment.

14. Medical providers who provided medical services under Medicaid provider agreements with Ohio Medicaid made claims for payments on Form HCFA 1500. Medical providers were assigned a Medicaid identification number for billing purposes. Medicaid only pays for treatment that is medically necessary and meets Medicaid billing criteria.

15. Defendant has been an approved Medicaid medical provider since June 1993. Defendant submitted Medicaid claims for reimbursement, using the HCFA 1500 claim form, pursuant to his written Medicaid provider agreement.

16. As part of the Medicaid provider agreement, the medical provider promises, among other things, to:

Maintain all records necessary and in such form so as to fully disclose the extent of the services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.

17. In addition to the language quoted at Paragraph 9 above, medical providers made the following statement on each Form HCFA 1500 claim submitted to Medicaid:

> **I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.**
>
> *** * * ***
>
> **SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.**
>
> **NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.**

Current Procedure Terminology (CPT) Codes

18. The American Medical Association (AMA) assigned five-digit numerical codes, known as Current Procedural Terminology (CPT) codes. The CPT codes, published annually by the AMA, were a systematic listing and coding of procedures and

services performed by medical providers. The CPT book included codes for office and home visits, known as evaluation and management (E&M) services, and for surgical and medical procedures, based on complexity, severity and the average time required to perform the service. Medical providers and health care benefit programs used the CPT Codes to describe the services and procedures for which the medical providers claimed and received payment. Each health care benefit program established fee reimbursements for each procedure and service described by a CPT code. CPT codes common to podiatry include the following:

19. CPT Code 11055 describes the paring or cutting of a single benign hyperkeratotic lesion (e.g., corn or callus). CPT Code 11056 describes the paring or cutting of two to four such lesions.

20. Palmetto GBA's Local Medical Review Policy for Foot Care states:

> Routine foot care is not a covered Medicare benefit. Medicare assumes that the beneficiary or caregiver will perform these services by themselves, and therefore, they are excluded from coverage.
>
> Routine foot care is defined as the cutting or removal of corns or calluses; the trimming, cutting, clipping, or debridement of nails; ...

21. CPT Code 11720 was "debridement of nail(s) by any method(s); one to five." CPT Code 11721 was the same procedure for "six or more" nails.

22. On or about September 20, 2001, Nationwide notified the defendant, through an educational letter that he was inappropriately billing for routine corn and callus care under CPT Codes 11055 and 11056. The letter stated that the patients for whom the defendant was billing those procedures "had no class findings or a systemic

condition that would allow coverage of lesion removals. It appears that routine callus care was being performed." The letter also noted that there were several undocumented services and reminded the defendant that "Medicare regulations require that services be medically necessary for the diagnosis or treatment of an illness or injury and that the need be supported by adequate documentation to insure proper payment."

23. CPT Code 11421 was a surgical procedure, "Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet genitalia; excised diameter 0.6 to 1.0 cm." The CPT code book defines "excision" as full-thickness removal (through the dermis) of a lesion, including margins. Excision of benign skin lesions includes local anesthesia and includes simple (non-layered) closure when performed.

24. Palmetto GBA's Local Medical Review Policy for Removal of Benign Skin Lesions states:

> Benign skin lesions are common in the elderly and are frequently removed at the patient's request to improve appearance. Removal of certain benign skin lesions that do not pose a threat to health or function is considered cosmetic and as such is not covered by the Medicare program. Benign skin lesions, to which this policy applies, include the following: benign skin tumors; seborrheic keratoses; skin tags; sebaceous (epidermoid) cysts; and viral warts.
>
> There may be instances in which the removal of benign skin tumors, seborrheic keratoses, skin tags, and sebaceous cysts is medically appropriate. Medicare will give individual consideration to the removal of a lesion not listed as covered in this policy if one or more of the following conditions is present and clearly documented in the medical record and with the claim:

- The lesion has one or more of the following characteristics: bleeding, intense itching, pain due to pressure, (e.g., plantar warts; dyspareunia).
- The lesion has physical evidence of irritation or inflammation, (e.g. purulence, oozing, edema, erythema, etc.).
- The lesion obstructs an orifice or clinically restricts vision.
- There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesional appearance.
- A prior biopsy is suggestive of lesion malignancy.
- The lesion has been subjected to recurrent physical trauma.

CPT codes 11055-11057 cover conditions almost exclusively confined to the foot. As such, they are excluded from coverage as routine foot care.

Treatment of corns and callosities is not a covered benefit unless certain conditions are met. The appropriate code to use if coverage criteria are met is CPT codes 11055-11057 (Paring or cutting of benign hyperkeratotic lesion).

The patient's medical record must contain documentation that fully supports the medical necessity for removal of benign lesions (warts, benign skin tumors, seborrheic keratoses, skin tags, and sebaceous cysts). This documentation must include, but is not limited to, relevant medical history, physical examination,(detailed description of the size and characteristics of the lesion), and results of pertinent diagnostic tests (e.g., pathology reports) or procedures.

The Defendant

25. The defendant, HAROLD M. JONES, was a doctor of podiatry licensed to practice in the State of Ohio. He maintained a practice at 5 Severance Circle, Suite 505, Cleveland Heights, Ohio 44118, within the Northern District of Ohio, Eastern Division.

II. THE FRAUDULENT SCHEME

26. From in or about December 1999, through in or about May 2006, HAROLD M. JONES, the defendant, did devise and intend to devise a scheme and artifice to defraud and to obtain money by means of false and fraudulent pretenses, representations and promises.

Improper Billing Codes

27. It was a part of the scheme to defraud that the defendant removed corns and calluses, and otherwise provided routine foot care, procedures reimbursable if at all under CPT Code 11055 or 11056, but claimed payment from health care benefit programs for those services using CPT Codes 11421, representing that he had performed surgical procedures for excision of benign lesions.

28. It was a further part of the scheme and artifice that the defendant, for the purposes of obtaining payment from health care benefit programs, and of concealing and covering up the scheme, placed false statements in patient records.

29. It was a further part of the scheme and artifice that the defendant claimed payment from federal health care benefit programs for the services and procedures described above, without maintaining written substantiation of the claimed services.

Billing for Services Not Rendered

30. It was a further part of the scheme that the defendant claimed payment from federal health care benefit programs for the services and procedures described above, when in fact he had not rendered any services or procedures.

Billing Under Another Medicare Provider Number

31. It was further a part of the scheme that the defendant claimed payment from federal health care benefit programs for services and medical procedures he rendered using the provider number of another podiatrist.

Counts 1-27
(Mail Fraud)

The Grand Jury further charges:

32. The allegations contained in paragraphs 1 through 31 of this Indictment are repeated and realleged as if fully set forth herein.

33. From in or about December 1999, through in or about May 2006, in the Northern District of Ohio, Eastern Division, and elsewhere, HAROLD M. JONES, the defendant, did devise and intend to devise a scheme and artifice to defraud and to obtain money and property by means of false and fraudulent pretenses, representations, and promises as described herein.

34. For the purpose of executing the foregoing scheme and artifice to defraud and to obtain money and property by means of false and fraudulent pretenses, HAROLD M. JONES did place and cause to be placed in an authorized depository for mail matter, according to the direction thereon, certain matters and things described below, consisting of checks to be mailed to the defendant at 5 Severance Circle, Suite 505, Cleveland Heights, Ohio 441118, located in the Northern District of Ohio, Eastern Division, in payment for podiatry services for beneficiaries of federal health care programs, with each mailing constituting a separate count of Mail Fraud, including, but

not limited to, the following:

Count	Date	Amount Paid	Payor/Beneficiary	Mailed From	Mailed To
1	10/26/04	$29.70	Medicare/ Jane Doe 1	Palmetto GBA Columbus, Ohio	Defendant Cleveland Heights, Ohio
2	10/26/04	$89.70	Medicare/ Jane Doe 2	Palmetto GBA Columbus, Ohio	Defendant Cleveland Heights, Ohio
3	10/22/03	$140.69	Medicare/ Jane Doe 3	Palmetto GBA Columbus, Ohio	Defendant Cleveland Heights, Ohio
4	11/05/03	$35.17	Medicaid/ Jane Doe 3	Auditor, State of Ohio Columbus, Ohio	Defendant Cleveland Heights, Ohio
5	4/20/04	$142.12	Medicare/ Jane Doe 3	Palmetto GBA Columbus, Ohio	Defendant Cleveland Heights, Ohio
6	5/05/04	$35.52	Medicaid/ Jane Doe 3	Auditor, State of Ohio Columbus, Ohio	Defendant Cleveland Heights, Ohio
7	8/24/04	$142.12	Medicare/ Jane Doe 3	Palmetto GBA Columbus, Ohio	Defendant Cleveland Heights, Ohio
8	9/09/04	$35.52	Medicaid/ Jane Doe 3	Auditor, State of Ohio Columbus, Ohio	Defendant Cleveland Heights, Ohio
9	6/08/04	$142.12	Medicare/ Jane Doe 4	Palmetto GBA Columbus, OH	Defendant Cleveland Heights, Ohio
10	3/31/04	$111.64	Medicare/ Jane Doe 5	Palmetto GBA Columbus, OH	Defendant Cleveland Heights, Ohio

Count	Date	Amount Paid	Payor/Beneficiary	Mailed From	Mailed To
11	4/28/04	$27.91	Medicaid/ Jane Doe 5	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
12	2/04/04	$9.70	Medicare/ Jane Doe 5	Palmetto GBA Columbus, OH	Defendant Cleveland Heights, Ohio
13	2/11/04	$37.12	Medicaid/ Jane Doe 5	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
14	2/25/04	$65.30	Medicaid/ Jane Doe 5	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
15	5/05/04	$142.12	Medicare/ Jane Doe 5	Palmetto GBA Columbus, OH	Defendant Cleveland Heights, Ohio
16	5/19/04	$35.52	Medicaid/ Jane Doe 5	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
17	8/03/04	$142.12	Medicare/ Jane Doe 5	Palmetto GBA Columbus, OH	Defendant Cleveland Heights, Ohio
18	8/18/04	$35.52	Medicaid/ Jane Doe 5	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
19	5/03/05	$143.69	Medicare/ Jane Doe 5	Palmetto GBA Columbus, OH	Defendant Cleveland Heights, Ohio
20	5/18/05	$35.93	Medicaid/ Jane Doe 5	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
21	9/01/04	$66.86	Medicaid/ John Doe 1	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio

Count	Date	Amount Paid	Payor/Beneficiary	Mailed From	Mailed To
22	9/17/03	$66.86	Medicaid/ Jane Doe 6	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
23	1/26/05	$66.86	Medicaid/ Jane Doe 7	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
24	5/26/04	$137.29	Medicaid/ Jane Doe 8	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
25	12/22/04	$108.43	Medicaid/ Jane Doe 8	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
26	2/24/05	$108.43	Medicaid/ Jane Doe 8	Auditor, State of Ohio Columbus, OH	Defendant Cleveland Heights, Ohio
27	7/19/05	$91.06	Medicare/ John Doe 5	Palmetto GBA Columbus, OH	Defendant Cleveland Heights, Ohio

All in violation of Title 18, United States Code, Section 1341.

Counts 28-50
(Health Care Fraud)

The Grand Jury Further Charges:

35. The allegations contained in paragraphs 1 through 31 of this Indictment are repeated and realleged as if fully set forth herein.

36. From in or about December, 1999, and continuing through in or about May, 2006, in the Northern District of Ohio, Eastern Division, and elsewhere,

the defendant, HAROLD M. JONES, knowingly and willfully executed, and attempted to execute, a scheme and artifice to defraud the health care benefit programs listed above, and to obtain, by means of false and fraudulent pretenses, representations and promises described herein, money and property owned by, and under the custody and control of, a health care benefit program including, but not limited to, Medicare and Ohio Medicaid, in connection with the delivery of or payment for health care benefits, items and services.

37. On or after the dates listed below, in the Northern District of Ohio, Eastern Division, and elsewhere, HAROLD M. JONES, having knowingly and willfully executed and attempted to execute the scheme and artifice to defraud the health care benefit programs described above, and to obtain, by means of the false and fraudulent pretenses, representations and promises described above, did knowingly submit the claims for reimbursement set forth below, all for the purpose of executing said scheme and artifice:

Count	Date of Claim	Amount of Claim	Health Care Benefit Program/ Beneficiary
28	October 12, 2004	$50	Medicare / Jane Doe 1
29	October 13, 2004	$125	Medicare / Jane Doe 2
30	October 8, 2003	$200	Medicare/Medicaid / Jane Doe 3
31	March 27, 2004	$200	Medicare/Medicaid / Jane Doe 3
32	August 11, 2004	$200	Medicare /Medicaid / Jane Doe 3
33	May 25, 2004	$200	Medicare / Jane Doe 4
34	June 11, 2003	$150	Medicare/Medicaid / Jane Doe 5
35	January 14, 2004	$125	Medicare/Medicaid / Jane Doe 5
36	April 14, 2004	$200	Medicare/Medicaid / Jane Doe 5

37	July 14, 2004	$200	Medicare/Medicaid / Jane Doe 5
38	April 13, 2005	$200	Medicare/Medicaid / Jane Doe 5
39	June 2, 2004	$75	Medicaid / John Doe 1
40	August 20, 2003	$75	Medicaid / Jane Doe 6
41	December 18, 2004	$75	Medicaid / Jane Doe 7
42	January 14, 2004	$200	Medicaid / Jane Doe 8
43	October 27, 2004	$150	Medicaid / Jane Doe 8
44	December 29, 2004	$150	Medicaid / Jane Doe 8
45	August 5, 2003 November 23, 2004	$150 $150	Medicare / John Doe 2
46	November 1, 2004 March 29, 2004 March 23, 2005	$150 $150 $150	Medicare/Medicaid / Jane Doe 9
47	May 23, 2003 October 15, 2003	$150 $75	Medicare/Medicaid / Jane Doe 10
48	January 23, 2003	$75	Medicare / John Doe 3
49	July 14, 2003	$75	Medicare/Medicaid / John Doe 4
50	July 25, 2005	$150	Medicare / Jane Doe 11

All in violation of Title 18, United States Code, Section 1347.

Count 51-54
(Aggravated Identity Theft)

The Grand Jury further Charges:

38. On or after the dates listed below, in the Northern District of Ohio, Eastern Division, and elsewhere, the defendant, HAROLD M. JONES, did knowingly possess and use, without lawful authority, a means of identification of another person, identified here by the initials "C.S.," to wit: the name and Medicare Provider number of "C.S."

during and in relation to a violation of Title 18, United States Code, Section 1347 (Health Care Fraud) by submitting the claims for reimbursement set forth below, using name and Medicare Provider number of "C.S "

Count	Date of Claim	Amount of Claim	Health Care Benefit Program/ Beneficiary
51	7/26/2005	$110.10	Medicare / Jane Doe 12
52	9/2/2005	$60.00	Medicare / Jane Doe 13
53	11/14/2005	$29.41	Medicare / Jane Doe 14
54	12/6/2005	$29.41	Medicare / John Doe 6

All in violation of Title 18, United States Code, Section 1028A.

A TRUE BILL.

Original document -- Signatures on file with the Clerk of Courts, pursuant to the E-Government Act of 2002.